

THE IMPACT OF LABELS ON PEER PERCEPTIONS  
OF PROGNOSTIC OUTLOOK

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## CHAPTER I

### INTRODUCTION

Are the benefits of using diagnostic labels worth the cost? This is a question that has been asked by many researchers. Many believe that while labeling may benefit individuals by enhancing things such as professional communication, there are also numerous harmful effects for the individuals being labeled. A common result of associating diagnostic codes with children is labeling bias. Labeling children can lead to differential expectations for the children being labeled (Brophy & Good, 1970; Cooper, Findley, & Good, 1982; Glock, 1972; Rosenthal & Jacobson, 1968). Children who are assigned a label might be negatively affected by labeling bias in school and a decrease in academic achievement often occurs after a child has been classified with a special education label (Rosenthal & Jacobson, 1968).

Now that children with disabilities are included in general education, there is a preponderance of research available that has studied the perceptions of nondisabled individuals toward the behavior and outcomes for students with handicaps. Some research has also examined how people's attributions change when they are first unaware and then become aware of a label. They have also examined how the attributions and bias of teachers, peers, and other school personnel, effect the outcome of a child's educational and social growth.

### *Statement of the Problem*

The educational outlook for individuals with disabilities has improved in recent years. Presently, 33% of people aged 25 to 64 with a non-severe disability and 22% of individuals with a severe disability are college graduates (U.S. Bureau of the Census, 2006). Much has been written about the detrimental effects of educational labeling (categorizing) children with special needs. Although labeling often is necessary to obtain services for children in schools, research has shown that teachers may have lower expectations for success regarding children with special education labels, and that these lower expectations may result in lesser achievement by students (Brophy & Good, 1970). Although much is known about the harmful effects of labeling on teachers' expectations, far less is known about the possible effects of special education labeling on the social acceptance of students with disabilities by their peers.

### *Purpose*

This experiment assessed participants' social acceptance and prognostic outlook toward peers who have (1) no disabilities, (2) autism, or (3) a learning disorder. It also explored the possibility that gender interacts with disability status in influencing participants' perceptions of peers with disabilities. This research study sought to determine whether or not there were differences in peer relationships of social acceptability and prognostic outlook, on the basis of a label or gender.

### *Research Questions*

1. Do people demonstrate differential attitudes of social acceptability and success in life for peers labeled with autistic disorder as compared to peers without a disability label?



2. Do people demonstrate differential attitudes of social acceptability and success in life for peers labeled with a learning disorder as compared to peers without a disability label?
3. If attitudes of social acceptability and success in life are significantly different for both peers labeled with learning disabilities and those labeled as autistic, are the differential attitudes different based on the label provided?
4. Do people demonstrate differential attitudes of social acceptability and success in life based on an interaction between gender and disability label (autistic disorder or learning disorder)?

#### *Hypotheses*

1. Participants will find individuals with autistic disorder less socially acceptable and less likely to succeed in life, compared with people with no disabilities.
2. Participants will find individuals with learning disabilities less socially acceptable and less likely to succeed in life, compared with people with no disabilities.
3. Participants will find individuals with learning disabilities more socially acceptable and more likely to succeed in life than individuals with autism, but less acceptable and less likely to succeed than people without disabilities.
4. Participants will find females more likely to succeed in life than males regardless of disability label.

## CHAPTER II

### LITERATURE REVIEW

#### *History of Disabilities and Labels*

Various researchers have attempted to determine whether existing psychological theories and research methods can be applied to the disabled population. Concerned with child development, Gliedman and Roth (1980) posed some questions for psychologists. In their studies, they were trying to discover whether or not the work of Piaget, Erikson, and Kohlberg could apply to the development of children with disabilities. They indicate that the interaction of a different biology and a stigmatizing society might cause these children to have a different developmental pattern than nondisabled children. Other researchers believe that existing theories are adequate to describe all children and that the disabled ought to be seen as deviant. However, Gliedman and Roth make a case that it would be valuable to research disabled children from these perspectives, and then adjust or expand the theories so that they better incorporate the 10% of the country's children found to be disabled.

Individuals with physical, intellectual, and psychological characteristics that depart from societal norms are called "handicapped." The Rehabilitation Act of 1973, as amended in 1978, defined a handicapped individual as:

Any person who (i) has a physical or mental impairment which substantially limits one or more of such person's major life activities including walking, seeing, hearing, speaking, breathing, learning, working, caring, for oneself, and performing manual tasks, (ii) has a record of such an impairment, or (iii) is regarded as having such an impairment. (Rehabilitation Act of 1973).

While most people think of the handicapped as consisting only of those who are deaf, blind, orthopedically impaired, intellectually disabled (mentally retarded), or mentally ill, there are also many relatively hidden conditions as arthritis, diabetes, heart and back problems, and cancer. Some people only have records of past impairments such as cancer in remission or cured, heart attacks, epilepsy, past diagnoses (Hobbs, 1975). Other people view themselves regarded as handicapped by others, including those who are obese or cosmetically disfigured. While they may not have any characteristics that affect their performance of any major life activities like seeing, hearing, speaking, moving, or breathing, but they may still feel as though they have been put into the handicapped stereotype.

#### *Prevalence of Children with Labels*

The United States Bureau of the Census (1983) provides data on the distribution of people with disabilities in America. It is interesting to see the comparison in figures when looking at the 1980's compared to current figures. In 1980, Bowe estimated a near 36 million people or about 15% of the population to have at least one disability. This estimate is also reliable with the 1976 United States Census Survey of Income and Education of 13.6% of the population. Gliedman and Roth (1980) estimated that 10% of children under 21 are handicapped. Estimates of the disabled population of working age

vary from a low of 8.5% by the U.S. Census of 1980 (Haber & McNeil, 1983) to a high of 17% as reported by the Social Security Administration in its 1978 survey (Haber & McNeil, 1983). Of those 65 years of age and over, 46% report a health impairment (DeJong & Lifchez, 1983). However these figures are limited because national surveys first ask for information about the existence of a long-term health condition and then, in the same question, confine the condition to one that limits or prevents a person from fulfilling a major social role—attending school, maintaining a home, or working at a job (Haber & McNeil, 1983; U.S. Bureau of the Census, 1983). Therefore, the way the question is worded may cause under-representation of disabled individuals who carry on what they consider to be their major social role even if they have a condition that could be diagnosed as limiting or preventing their ability to do so. Even though an estimated 10% of children under 21 are handicapped, the prevalence of disabilities in the noninstitutionalized population between the ages of 16 and 24 is only a little bit more than 3% (U.S. Bureau of the Census, 1983). The percentage difference could be due to sampling procedures in the diverse research studies or by differences in what is considered to be handicapped.

In contrast to the 1980s percentage of people with disabilities, our current figures show 51.2 million people have some level of disability (U.S. Bureau of the Census, 2006). They represent 18% of the population. Out of those people, 32.5 million people or 12% percent of the population have a severe disability. When specifically looking at children, 11% or 4 million children ages 6 to 14 have a disability (U.S. Bureau of the Census, 2006). The highest of any age group are people 80 and older with 72% having a disability. Females have a higher prevalence than males, with 20% and 17% of males.

On the other hand, among children under 15, boys were more likely than girls to have a disability (11% versus 6%). A total of 6% of citizens have limitations in cognitive functioning or a mental or emotional illness that interferes with their daily activities. This includes those with Alzheimer's disease, depression and mental retardation. Of those with specific disabilities, 1.8 million people age 15 and older report being unable to see, 1 million age 15 and older report being unable to hear, 2.6 million age 15 and older have some difficulty having their speech understood by others. Of this number, 610,000 were unable to have their speech understood at all. There are 10.7 million people (4%) age 6 and older who need personal assistance with one or more major life activities. Of people ages 25 to 64 that have a nonsevere disability, 33% perceive their health status as being "very good" or "excellent." This compares with 13% of those with a severe disability and 73% of those without a disability. As of 2004, there were 2.6 million Americans serving our nation who received compensation for service-related disabilities (U.S. Bureau of the Census, 2006).

The disabled population has acquired numerous rights that were previously denied and have experienced the benefits from institutional and structural changes that have and will aid their inclusion into the moral and human community (APA Task Force Report, 1984; Weickers, 1984). These changes have been facilitated by the progress of the disability rights movement that has become apparent as a challenge to the conventional role assigned to the disabled by society. The movement is one that strives for collective and psychological transformation by attempting to remodel laws, practices, institutions, and environments as a whole that have excluded the handicapped from many features of life. They demand that policy makers and service providers consult the disabled on all

decisions that may have an effect on them, (Anspach, 1979; Roth, 1983). Due to these rights, handicapped individuals are protected from discrimination in education and employment anywhere that there is federal money. In the past, labels of diagnostic categories were incorrectly thought to predict success at a job with a diagnosis and to deny anyone who did not meet the highest standards of health.

There are multiple reasons to believe that disabled people are at risk, as they are often the victims of child abuse, domestic violence, rape, crime, and family abandonment, as well as substance abusers. Disability is associated with many social and economic disadvantages, for example the disabled population disproportionately achieve low levels of education. However, education outlooks for those with disabilities are improving, as 33% of people ages 25 to 64 have a nonsevere disability and are college graduates. This compares with 43% with no disability and 22% with a severe disability (U.S. Bureau of the Census, 2006). In 1983, U.S. Bureau of the Census reported only 4.6% of those with disabilities completed college. In addition, ratings show that as age increases, so does work disability. Only 3.3% of those between 16 and 24 are disabled, and only 7% of those between 35 and 44 have a work disability. For people between 55 and 64, however, 24.1% report a work disability (U.S. Bureau of the Census, 1983). These two disadvantages are especially interrelated because education narrows the gap between those with and those without a work disability in both labor force participation and annual earnings.

Of the people with work disabilities between the ages of 16 and 64, half of them portray themselves as severely handicapped or incapable of working at all (DeJong & Lifchez, 1983). However, there are other people with the same diagnosis, yet could be

employed in the work force and may portray themselves as having little to no limitation. An important question to ask is: what accounts for these differences? How does a diagnosis—such as Emotional Disturbance—interact with motivation, education, intelligence, attitudes, gender, race, and class to generate such diverse outcomes?

Compared to percentages of American's with work disabilities in 1983, 6% of 16- to 64-year-olds reported the presence of a medical condition that makes it difficult to find a job or remain employed. The amount of people ages 21 to 64 having some type of disability and also employed in the last year is 56%. There are 44% of people with a nonsevere disability who work full time, year-round, 53% without a disability, and 13% with a severe disability. The median income for people with a nonsevere disability is \$22,000, \$25,000 for those with no disability, and \$12,800 for those with a severe disability. For those with household incomes of \$80,000 or more, there were 18% of people with a nonsevere disability, and 26% without a disability, and 9% of those with a severe one. For people ages 25 to 64, the poverty rate is 11% for those with a nonsevere disability, 26% for those with a severe disability, and 8% of those without a disability (U.S. Bureau of the Census, 2006).

### *Current Labeling Systems*

The term “diagnosis” is generally used in clinical settings with the Diagnostic and statistical manual of mental disorders (DSM-IV-TR) labels (e.g., schizophrenic, attention deficit hyperactivity disorder, etc.). In the school settings, the term “classification” is typically used when identifying special education labels using the Individuals with Disabilities Education Improvement Act (IDEIA; e.g., learning disability, emotional disturbance.). Both of these systems are used with the general purpose of assigning a

label to an individual and are frequently used interchangeably (Merrell, 2006).

The school systems adhere to the labels created by the Individuals with Disabilities Education Improvement Act. There are typically thirteen categories that are commonly used to identify students (P. L. 94-142, P. L. 101-476, Alper, Schloss, & Schloss, 1994). These areas are autism, deaf-blindness, deafness, emotional disturbance, hearing impairment, mental retardation, multiple disabilities, orthopedic impairment, other health impairment (e.g., asthma, attention deficit hyperactivity disorder, diabetes, epilepsy, heart condition, hemophilia, lead poisoning, leukemia, nephritis, rheumatic fever, sickle cell anemia and tourette syndrome), specific learning disability, (e.g., perceptual disabilities, brain injury, minimal brain dysfunction, dyslexia, developmental aphasia), speech or language impairment, traumatic brain injury, and visual impairment (including blindness).

### *Role of Special Education*

Most states use a categorical classification system as the fundamental structure to organize special education today (Ysseldyke & Algozzine, 1995). For students to be considered exceptional they must (1) meet the criteria for being classified as exceptional, and (2) require a modification of school practices or services to develop to maximum capacity (Ysseldyke & Algozzine, 1995). Special education has been utilized to provide instruction designed for students with disabilities or gifts and talents who have special learning needs. Since the late 1970s, enrollment in special education has been growing rapidly. There were fewer than 300,000 students classified as disabled in the 1970s (Ysseldyke & Marston, 1998). If the professionals involved decide that a student meets specific eligibility requirements, then the student is permitted to receive special education



services. Usually determination of eligibility is based on student performance on tests (Ysseldyke & Marston, 1998).

This special education eligibility process has resulted in a process that is expensive (Ysseldyke & Thurlow, 1984), inconsistent in outcomes (Ross, 1990; Shephard, Smith, & Vojir, 1983; Singer, Palfrey, Butler, & Walker, 1989), and often subverted. Numerous research studies have concluded that there is no evidence that this categorical identification system contributes to enhanced student performance (Heller, Holtzman, & Messick, 1982; NASP/NASDSE, 1994; Ysseldyke & Thurlow, 1984). Shinn, Good, Parker (1998) argue that there are five fundamental issues that suggest current labeling and categorization procedures require reconceptualization. These include: (1) the distinction between categories is too variable, (2) the distinctions between categories are not educationally meaningful, (3) a lot of students with severe educational needs are denied services, (4) distinguishing between categories is an inefficient use of resources, (5) extensive resources are used on categorization that could be more effectively used for intervention.

#### *Differences in State Prevalence and Definitions*

The percentage of students in the mild disability categories fluctuates significantly by state (Shinn et al., 1998). According to the *Seventeenth Annual Report to Congress on the Implementation of the Individuals with Disabilities Educational Act* (1994), during the 1992-1993 school year, the percentages of students with learning disabilities varied from a low of 2.8% in Georgia to a high of 9.3% in Massachusetts. The distributions of disability categories within states raises even more concern (Shinn et al., 1998). For instance, Alabama categorized 28% of its special education population as mentally

retarded while New Jersey classified only 3%. Delaware identified 70% of its special education population as LD, while Georgia only identified 33% as LD. Indiana classified 31% of its special education population as speech and language impaired while New York classified only 11%. (Shinn et al., 1998).

Complicating the difficulty of evaluating the prevalence differences of disability categories further is the inconsistent definitions of each disability. There are not consistent criteria for the mild disability categories from state to state. Federal definitions in IDEIA are fairly ambiguous and federal attempts to provide regulations have been resisted. States are required to provide their own eligibility regulations consistent with the definitions in IDEIA (Shinn et al., 1998). However, states operationally define this in a wide-range of different ways. For example, as many as 11 different methods have been used to define learning disabilities (Hamill, 1990).

#### *Reliable and Valid Identification*

The reliability and validity of the psychometric and functional differences among disability categories has warranted significant debate. There is a preponderance of research showing that students identified as having a disability can be differentiated from those who do not have a disability. School psychologists are called upon to distinguish out of all the students having difficulties in school, which students are eligible for special education services, and then which category is each student eligible under. (Ysseldyke & Marston, 1998)

There has been some question as to whether students who are classified and served meet the state or federal criteria for being classified and served (Ysseldyke & Marston, 1998). Garrison and Hammill (1970) found that 66% of those identified as educable

mentally retarded (EMR), actually did not qualify under EMR criteria. Norman and Zigmond (1980) did not find any specific defining characteristics for learning disorder. Shephard, Smith, and Vojir (1983) discovered that fewer than half of 790 Colorado students identified with as having a learning disorder met federal criteria for learning disorder. Algozzine, Christenson, and Ysseldyke (1982) found that 92% of students referred are tested and 72% of them are pronounced eligible. When this study was replicated in 1994 (Ysseldyke, Vanderwood, & Shriner, 1997), identical rates were found. A study investigating the differences between students who were low achieving (LA), learning disabled (LD), and mildly mentally retarded (MMR) found that 62% of the LD group could be differentiated from the LA group, 68% of the LD group could be distinguished from the MMR group, and 67.5% of the LA group could be differentiated from the MMR group (Gresham, MacMillan, Bocian, 1996).

The psychometric performance of individuals identified as having a learning disorder was compared with individuals considered to be low achievers (Ysseldyke, Algozzine, Shinn, & McGue, 1982). They found that the two groups had significant overlap in test performance, and argued a case that the groups could not be distinguished reliably using psychometric measures. These same students did not differ on measures of their functional performance in classrooms (Shinn, Deno, Ysseldyke, & Tindal, 1986). A meta-analysis procedure was used to re-evaluate the Ysseldyke et al. data from 1994 by Kavale, Fuchs, and Scruggs (1994). They argued that the learning disorder group actually performed more poorly than the low achiever group. Algozzine, Ysseldyke, and McGue (1995) countered the Kavale, et al. (1994), paper revealing that unsuitable procedures were used in the reanalysis. Ysseldyke and Marston (1998) argue that diagnostic efforts

to distinguish between labels should be diminished, and that instructional efforts should be significantly increased to help all individuals achieve improved outcomes.

### *Labeling Bias*

Professionals and researchers in the field of psychology have increasingly debated the value of assigning diagnostic and/or classification labels to children over the past few decades. This is not too surprising considering the label associated with a child determines the way they are evaluated, described, and served. The classification system used to identify a label shapes practices related to intervention, training, certification, and they also impact funding decisions. The use of labels has had both positive and negative effects for professionals as well as the individuals being labeled. An unfortunate yet common result of associating these diagnostic codes with children is labeling bias.

Labeling bias has been referred to as the expectations that people may develop towards a person who has been given a particular label (Fox & Stinnett, 1996). The phenomenon is one that encompasses affective, cognitive, and social aspects, among even professionals of the highest education, knowledge, and skill. People make attributions about others from their own perceptions and what they hear (Tesser, 1995). Labeling children can lead to differential expectations for the children being labeled (Brophy & Good, 1970; Cooper, Findley, & Good, 1982; Glock, 1972; Rosenthal & Jacobson, 1968).

While there has been some discussion of the possibility of getting rid of the current labeling system, as for now, the law states that a child must be diagnosed with a disorder to be considered for special education services (Reger, 1982). Thus, a label is assigned to a child due to this categorization. The use of labels was initially linked with a positive intention in special education. However, at times they have been known to hinder the

success of children getting special education services within the school context (Field, Hoffman, St. Peter, & Sawilowsky, 1992; Foster & Ysseldyke, 1976; Rosenthal & Jacobson, 1968).

A label, regardless of the positive or negative attributions attached to it, may affect an individual's success. The academic success or failure of a person can be affected just by receiving the information that the individual has been diagnosed with a disorder. Unfortunately, the latter of the two usually occurs, as a decrease in academic achievement is common after a child has been classified with a special education label (Rosenthal & Jacobson, 1968). It is a possibility for a label to become permanently attached to a person and the attributions can grow to be institutionalized (Palmer, 1983). In many cases, a child is evaluated, assigned a label, and then treated differently due to the label (Carroll & Reppucci, 1978; Fogel & Nelson, 1983; Smith, Flexer, & Sigelman, 1980). Children who are assigned a label might be negatively affected by labeling bias in school. People have different expectations for labeled children, depending on their relationship with the child, whether they are parents, teachers, peers, school psychologists, or other school personnel. School personnel can interpret the label negatively, and might presume a student is incapable of being as successful as nonlabeled students (Field, Hoffman, St. Peter, & Sawilowsky, 1992; Foster & Ysseldyke, 1976; Rosenthal & Jacobson, 1968). When people become aware that a child has been assigned a diagnostic label, they may expect certain behaviors for the child (Allport, 1954). Teachers have a tendency to be influenced by a child's label, rather than having parallel expectations for all students. School personnel expect a labeled student to perform more poorly on a variety of educational and social tasks than "normal" students (Gillung &

Rucker, 1977).

Some of the negative results associated with labeling a child include rejection by peers, decrease in academic ambition, lowered self-concept, biased reacting by parents and teachers, and reduced post-school adaptation (Palmer, 1983). There is strong evidence to support that teachers make judgments and form expectations for a labeled student based on information received from other school personnel, before they ever observe or interact directly with the student (Carroll & Reppucci, 1978; Fogel & Nelson, 1983; Smith, Flexer, & Sigelman, 1980). Considering the impact that a label can have on a child, it is concerning to see that labels are not consistent from state to state. While the label given to a child varies across states, the diagnosis in most states is based on the same, or similar criteria (Skiba, Grizzle, & Mink, 1994).

### *Observation Bias*

An area of bias which is particularly relevant to school psychologists is observer bias. Observation bias may occur in various settings and situations including in school settings, experimental situations, clinical settings, and psychological testing situations (Rosenthal & Jacobson, 1968). In the school setting, observation bias may occur for a school psychologist who is observing a child in the classroom as part of the assessment procedure. Another potential situation is in the research setting when studies are looking for inter-observer or inter-rater reliability. In everyday life, people tend to see what they want to see. With our current resources, it is difficult, if not impossible to remain completely objective during an observation. There are often ill-defined codes and categories used during observation and they tend to be inconsistent across studies. Furthermore, the school psychologists observing, or even research participants are

usually aware of the purpose of observation and tend to (unwittingly) develop expectations. Research has shown that observers can be significantly influenced to produce data that is consistent with the hypothesis under test or the expectations that they hold (Rosenthal & Jacobson, 1968).

During observation, both objective and subjective elements can impact an observer's definition of the situation (Thomas, 1923). Objective elements are those that have a verifiable existence which a scientist or any other person could identify. These elements consist of physical features and societal norms related to the situation. The subjective elements are those connected to the observer's unique perspective, past experiences with comparable situations, their expectations of the kind of behavior found in such a situation, and their attitudes and values associated with the situation. It is likely that the subjective elements could be the main influence in the definition of a situation. Thus, because an observer's definition of a situation effects their observing and recording, the data resulting from their observations will be biased or distorted (Stebbens, 1967).

### *Multicultural Competence*

There is a need for assessment training to reduce cultural bias and cultivate awareness and practice of culture-specific service delivery styles. In the United States, over 30% of the population and over one-third of those in need of mental health services are now of non-European origin (Dana, 1994). Before the 1990s, there was not much awareness amongst Caucasian assessment practitioners that culturally competent assessment was necessary for ethical practice (Dana, 1994). While training for multicultural competence of counseling and clinical psychologists has been improving

(Pope-Davis & Coleman, 1997), some research suggest that practitioners still do not feel qualified to provide services for these populations (Allison, Crawford, Echemendia, Robinson, & Kemp, 1994; Allison, Echemendia, Crawford, & Robinson, 1996).

Unintentional assessor bias can be present in the form of ethnocentrism that reduces or denies differences among persons (Bennett, 1986) and by stereotyping resulting in selective observation of negative behaviors (Li-Repac, 1980). This bias can effect training, supervision, self-examination, and immersion in another language and culture. Bias in service delivery occurs when Anglo-American social-professional customs are used with clients of diverse cultural/racial identities. Assessment training can cultivate awareness and practice of culture-specific service delivery styles (Dana, 1998).

#### *Expectancy Theory*

Another potential source of bias related to labels is expectancy bias. Expectancy bias can occur even amongst the most well trained professionals. It is important to examine the expectations that people hold for disabled children because studies show that they can have a large impact on the outcomes of perceived success, intervention, and even the actual success of the student. Research shows that the expectation teachers hold for labeled children effect their willingness to implement interventions in the classroom, the way they treat a child, and the success the child has in reaction to the way they were treated. This is significant because it is becoming more common for teachers to be the primary implementers of specific interventions that have typically been designed by a school psychologist to improve student academic or behavioral functioning within the general education classroom. Therefore, teachers have a major influence on the academic and social success of the child. However, it is common for teacher's to lower their



expectations for a student with a label. The Expectancy Model is useful in explaining the concept of labeling bias and the effects that teacher's, school psychologist, and other school personnel have in student's success outcomes. The Expectancy Model is defined as

the strength of a tendency to act in a specific way depends on the strength of an expectation that the act will be followed by a given outcome and on the attractiveness of that outcome to the individual (Vroom, 1964, p.3).

Expectancy theory asserts that a child will be motivated to a higher level of performance when there is a belief that a higher level of performance will lead to positive performance appraisal. Then this will lead to an awareness of personal goal in the form of a reward (Vroom, 1964). Multiple studies have found that student performance is positively correlated with teacher expectations. Teacher's expectation of performance can affect the way the child performs. Children can have positive outcomes on educational tasks from the influence teacher's can have by using extrinsic motivation (Brophy & Good, 1970; Cooper, Findley & Good, 1982; Glock, 1972, Gottfriedson, Marciniak, Birdseye, & Gottfriedson, 1995; Kohn, 1973; Rist, 1970; Rogers, 1998; Rosenthal & Jacobson, 1968).

Depending on the label assigned to a student, teachers change their behavior accordingly. Children are very capable of acknowledging nonverbal cues from people and they are able to recognize the confidence or lack of confidence a teacher has in them as a student. When a teacher views a student as a low achiever, it is astonishingly obvious. Gottfriedson et al. (1995) describes these obvious cues as giving less attention to the child, being more critical, giving disingenuous praise, giving the student less

opportunities to respond, making little eye contact, rarely using student suggestions and ideas, directing fewer smiles toward that child, providing less frequent and less informative feedback, repeatedly interrupting student comments, and decreasing the amount of wait time. On the other hand, when a teacher views a student as a high achiever, they motivate the student by encouraging their educational success in the classroom, provide them give praise, and ask them for favors. These students receive much more positive cues and behaviors from the teacher. They are also given more freedom within the classroom. Regardless of whether teachers give off positive or negative cues, students form both sides change their behavior in accordance to the cues given to them by teachers. Furthermore, students who are given lower expectations from teachers perform lower on tasks, while students who are given higher expectations from teachers perform better on tasks. This is the foundational ground of the Expectancy Model (Brophy & Good, 1970).

Various other researchers conducted some research related to the Expectancy Model and found comparable outcomes. Gillung and Rucker (1977) considered the initial description that a teacher hears about a child to be a significant dynamic related to the expectations the teacher would hold for a child. They recognized that teacher's were beginning to play a larger role in educating exceptional students. They were against the use of labels and felt that they should be avoided in all contexts. Their study separated participants into two separate group conditions. One group was presented a scenario with a labeled student and provided descriptive behaviors. The other group was presented a scenario with an unlabeled student, the same descriptive behaviors that the first condition was given were provided. Gillung and Rucker had the goal of discovering whether

teacher expectations were different for students who were labeled than for students who were not labeled. The findings indicated that regular education and special education teachers had lower expectations for students who were labeled than for students who were not labeled.

### *Attribution Theory*

Attribution theory may be useful when attempting to interpret teachers' attributions of disabled students, problematic students, or struggling students. Attribution theory originated with Fritz Heider (1958) who indicated that people frequently have trouble making sense of the world, and regularly analyze and discuss the reasons for events occurring the way they do, in particular, when the event is unexpected or negative. The phenomenon of locus of control is related to labeling bias and attribution theory. This concept focuses on the way people perceive events as being internally or externally controlled forces. Depending on the circumstance and the individual, one may perceive some events as internally controlled and others as externally controlled. Some people may tend to focus on the external environment out of their control as explanations for most phenomena. Other people may view their own skills and efforts as the causal explanation for events occurring, thus concentrating on internal forces (Hunt, 1993). Myers (2002) defines Locus of Control as the degree to which individuals perceive outcomes as caused by chance or exterior forces-- external control--or by their own efforts and actions--internal control.

Some researchers have considered the factor of controllability to be a separate dimension of attribution theory. This is when a teacher may view the student's high or low achievement to be within the child's control, or outside of the child's control. Along

with internal/external locus of causality and controllability, stability has been found to represent another dimension of attribution theory meant to explain outcomes (Clark, 1997). The stability or instability can be present in teacher's views of student behavior and academic functioning. For example, a teacher may recognize a student's high or low achievement to be a stable factor over time, or one that is inconsistent. These dimensions of attribution theory relate to how people interpret other people's behavior, and the reasoning behind why they make these exclusive interpretations.

The majority of empirical research studies related to attribution theory in the past have focused on the distinctions in teacher attributions for high and low achieving students, as well as effects of teachers' attributions for student success or failure. For example, Graham and Weiner (1986) investigated the connection between teachers' pity and anger towards students and the preference to use rewards and punishment. Emotional reactions in teachers, such as anger or pity, are frequently triggered by negative classroom events. Interestingly, the specific emotional experience the teacher had was directly related to the degree of control they perceived the student to have over the incident. For instance, if a teacher thinks that a student did poorly on an exam or task due to a lack of effort, the teacher is more apt to feel anger and discipline the child because the failure was an external factor, which the child had control over.

### *Social Psychological Influence*

Many social scientists consider attitudes to be the origin of bias and dysfunction associated with disability. These attitudes include stereotypes, prejudices, and self-defeating thoughts and behaviors of some disabled persons themselves, which have a tendency to limit the opportunities for handicapped people to partake in the typical life

roles and functions (Fenderson, 1984). Richardson (1976) commented on the state of handicapped people in our society by claiming that there is enough research evidence to show that people who have a physical disability have a social disadvantage in initial social encounters, and the disadvantage is not only powerful but also pervasive. Goffman (1963) proposed that people do not view disabled individuals as completely human and thus tolerate and even justify the mistreatment of the stigmatized, yet would not accept that mistreatment for the rest of humankind. Deutsch (1974) makes a case that people will accept injustices toward others if they deem their fate and the fate of the victims as opposite, or if they can eliminate the victims from their idea of the community that they hold moral standards for. Various researches have used questionnaires and rating scales to measure attitudes of the nondisabled toward the disabled. Results reveal a predominance of negative attitudes and show that positive ones, when present, are usually distorted and stereotypic. They found that some common views of disability were punishment for sin; disability causes a person to be dependent, helpless, and socially and economically lower in all aspects of life; handicapped citizens experience severe emotional consequences (Siller, Ferguson, Vann, & Holland, 1967; Yuker, Block, & Young, 1966).

Other research studies of the behavior of the nondisabled toward the disabled demonstrate an emotional arousal effect that occurs in a nonhandicapped person when in the presence of another who is disabled or is thought to be. At the very least, these emotions hinder common social interaction. Due to the possibility of an awkward interaction, nonhandicapped people may choose to avoid social communication with the disabled. They may also behave in a more formal manner and in distorted ways if they

must interact with handicapped persons (Doob & Ecker, 1970; Katz & Glass, 1979; Kleck, 1969; Kleck, Ono, & Hastorf, 1966; Richardson, 1976). Several researchers have written about how uncommon it is for those with disabilities and those without to have any meaningful social interaction. Nonhandicapped people see only the disability; they usually cannot focus on personal characteristics that they would normally use in evaluating and forming interpersonal relationships (Davis, 1961; Goffman, 1963; Richardson, 1976). Even though most of the psychological research has centered those with immediately noticeable physical deviations such as vision, hearing, speech, mobility, and cosmetic differences, the same consequences are apparent for those with nonvisible handicaps as soon as someone became aware of them (Goffman, 1963; Schneider & Conrad, 1980).

Research indicates that people may experience an arousal of anxiety in the presence of handicaps because they may perceive them as lacking competence and beauty (Hahn, 1983). Beauty is believed by some to be desirable, deserved, and it is assumed to be associated with characteristics of kindness, sensitivity, and amiability. Consequently, those considered unusual or unattractive are avoided because they are assumed less deserving and less desirable than those considered beautiful. People might be uncomfortable or even repulsed by anything seemingly awkward or unusual on the part of the handicapped. Nonhandicapped people might have a fear that they will not be able to uphold a smooth and simple interaction with the handicapped (Berscheid & Walster, 1974).

Lerner (1980) found that in general, people perceive the world as a just one, where people get what they ultimately deserve. However, in order for nonhandicapped people to

sustain their belief in justice, disabled people are seen as deserving their disability. The mere thought of a disability may produce anxieties related to weakness, loss, and vulnerability, especially in a culture prizing autonomy competence. As a result, the nonhandicapped person may treat the disabled person as if they have no capability to make any decisions about his or her life and has no normal functions (Rubin & Peplau, 1975). However, some researchers may believe that there is some truth in this, Bowe (1980) argued that the federal government spends 10 times as much on what he termed “dependence programs” for the handicapped as on programs to increase independence. Research shows that stereotyping and social categorizing of people into groups increases between-group differences and reduces within-in group differences (Tajfel, 1982). Tajfel discovered 30 different studies with similar results showing subjects to act with favoritism for an in-group and in opposition to an out-group. This data implies that people are inclined to favor members of their in-group, even when there is no explicit conflict between groups (Tajfel, 1982).

### *Emotional Disturbance*

Out of the thirteen IDEIA categories, the one that seems to elicit the most bias in teachers is Emotional Disturbance. In relation to school bias, Emotional Disturbance elicits more negative ratings than the others labels (Foster, Algozzine, & Ysseldyke, 1980; Levin, Arluke, & Smith, 1982; Stein & Merrell, 1992; Ysseldyke & Foster. 1978). The definition for Emotional Disturbance (ED)/ Serious Emotional Disturbance (SED) is:

- (i) The term means a condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree which adversely affects a child’s educational performance: a) an inability to learn which cannot be

explained by intellectual, sensory, or health factors; b) an inability to build or maintain satisfactory relationships with peers and teachers; c) inappropriate types of behavior or feelings under normal circumstances; d) a general pervasive mood of unhappiness or depression; or e) a tendency to develop physical symptoms or fears associated with personal or school problems. (ii) The term includes schizophrenia. The term does not apply to children who are socially maladjusted, unless it is determined that they have an emotional disturbance (IDEIA, 2004; PL101-476, 1999).

Due to a variety of reasons, the label that has received the most criticism is Emotional Disturbance. In addition to the heightened bias attached to this particular label, there are some problems within the definition itself. The criteria in the definition are not equivalent to the empirical subtypes of child psychopathology (McConaughy, 1993). The category for Serious Emotional Disturbance is actually a heterogeneous cluster of children with: a) externalizing problems; b) internalizing problems; and c) comorbid internalizing and externalizing problems. Psychologists are left to make a subjective decision for diagnosis due to unclear sections of the definition; e.g., “over a long period of time and to a marked degree which adversely affects a child’s educational performance,” Therefore, the assessment of the problems severity, duration, and impact on educational performance is most likely subjective (Stinnett, Bull, Koonce, & Aldridge, 1999). As a result of using the term “Serious Emotional Disturbance”, some children are not identified who may be eligible for special education services under that category (Forness & Knitzer, 1992; McConaughy, Mattison, & Peterson, 1994; U.S. Department of Education, 1996). Furthermore, experts disagree about the social maladjustment



exclusion clause (Forness, 1992; Forness & Knitzer, 1992; Nelson, 1992; Skiba & Grizzle, 1991, 1992; Skiba, Grizzle, & Minke, 1994; Slenkovich, 1992a, 1992b; Zirkel, 1992).

In order to minimize pessimistic prognostic judgment, it may be beneficial to include, present, and explain the definitional criteria to teachers, parents, and other school personnel when a child has received a label. Stinnett, Bull, Koonce, & Aldridge (1999) found in their study that the negative prognostic judgment was reduced when definitional criteria for Serious Emotional Disturbance (SED) was presented. It would be advantageous to study how the presentation of definitional criteria of other disorders effects label judgments.

## CHAPTER III

### METHOD

#### *Introduction*

The study used a 2 x 3 experimental research design and assessed students' attitudes of social acceptability and prognostic outlook of peers who were either normal functioning, autistic, or learning disabled. In addition, gender was investigated to indicate whether these impacts varied for a male peer with a disability than for a female peer with a disability.

#### *Participants*

Participants included 163 undergraduate college students enrolled in education and introductory psychology courses at Oklahoma State University. Of the 163 students asked to be involved in the study, 100% participated. There were 63 males (38.7%) and 100 females (61.3%). Age of the participants ranged from 18 to 38 ( $M$  age = 21.64 years,  $SD$  = 3.29).

#### *Procedure*

One-hundred and sixty-three packets were randomly distributed to undergraduate students in education and psychology classes at Oklahoma State University. Participants were solicited in their classes during the spring semester. Their participation in the study was voluntary. Research packets were distributed during a class period and the student

participants completed them under the supervision of the research investigator and course instructor. Participants were under no time restrictions to complete the surveys and everybody completed them within 15-20 minutes. For participating in the study, students had the opportunity to earn extra credit, upon the discretion of their professor. Alternative opportunities to receive extra credit were given to students who did not wish to participate in the research study. The instructions for completing the research package were given orally by the research investigator and confidentiality of all data was guaranteed (see Appendix A).

Each packet contained an informed consent form for them to turn in and an informed consent form for them to keep (See Appendix B), the Attitudes Toward Disabled Persons Scale (Yuker et al., 1966; see Appendix C), a vignette (See Appendix D), the Prognostic Outlook survey, (Fox & Stinnett, 1996; see Appendix E), an Autistic Disorder knowledge survey (see Appendix F), a Learning Disorder knowledge survey (see Appendix G), and a general demographics survey (see Appendix H). The forms were placed in a specific order for the purpose of measuring the participant's attitudes towards individuals with disabilities before they saw the other instruments to prevent demand characteristics from interfering with participants' responses. The consent forms were handed out and collected first and then the instructions were read aloud from the administration script. Then the packets were distributed with the Attitudes Toward Disabled Persons Scale (Yuker et al., 1966) first, the vignette and Prognostic Outlook survey followed with a note at the top of the Prognostic Outlook survey saying, "Please complete this scale in reference to the case description and diagnosis you just read".

Following was an autistic disorder knowledge survey, a learning disorder knowledge survey, and a general demographics survey.

Participants were randomly assigned to six groups. Members of each group were assigned a vignette depicting one of the following: (1) a typical male peer, (2) a male peer with autistic disorder, (3) a male peer with a learning disability, (4) a typical female peer, (5) a female peer with autistic disorder, or (6) a female peer with a learning disability. The six vignettes described the same scenario, varying only the gender and disability label of the person depicted. This resulted in six possible cells. An attempt was made to have an equal number of participants in each cell (see Appendix I).

### *Instruments*

#### *Attitudes Toward Disabled Persons Scale*

The Attitudes Toward Disabled Persons Scale (ATDP; Yuker et al., 1966) is a unidimensional scale measuring a general attitude toward individuals with disabilities. The instrument consists of 30 Likert items rated on a 1-6 scale (1: I agree very much, 2: I agree pretty much, 3: I agree a little, 4: I disagree a little, 5: I disagree pretty much, 6: I disagree very much). The results can be interpreted in terms of perceived differences between people with disabilities and those without disabilities (Yuker et al., 1966). A high score, relative to other scores indicates that the respondent perceives individuals with disabilities to be similar to individuals without disabilities. A score that is low would indicate that the respondent perceives individuals with disabilities to be different from individuals without disabilities. Most of the items on the ATDP suggest that where there is a difference perceived, this difference has negative connotations. These negative connotations suggest that a low score reflects the respondent's attitude that individuals

with disabilities are different and also possibly disadvantaged or inferior. The ATDP is reliable and highly correlated with other measures to make it a useful research tool when it is used with groups of respondents. Reported test-retest reliability is 0.83 and reported split-half equivalence reliability is 0.87 (Yuker et al., 1966; see Appendix C)

#### *Prognostic Outlook Survey*

The Prognostic Outlook survey (Fox & Stinnett, 1996) consists of nine evaluative questions that were designed to reflect the participants' judgment of a student's likelihood of future success or failure, the student's likelihood of disruptive behavior, the likelihood of future problems in interpersonal relationships, and overall level of adjustment. These items are rated on a scale of 1 to 10, with "1" meaning extremely unlikely and "10" meaning extremely likely. Higher scores are indicative of better prognostic outlook than lower scores. Numeric values for each question are summed and those values are used for all further analysis (Fox & Stinnett, 1996). The reliability analysis of the scale produced a Chronbach's alpha coefficient of 0.87 ( $M = 68.44$ ,  $SD = 13.60$ ; see Appendix E)

#### *Knowledge Surveys*

Two knowledge surveys were created for this study to ascertain participants' understanding of autism and learning disorders. Each survey consists of nine true/false questions. The first eight questions were based on the DSM-IV-TR criteria. The purpose of these surveys was to measure participants' knowledge about autistic disorder (see Appendix F) and learning disorders (see Appendix G). The eight scores were summed to create a total knowledge score of autism, and then a total knowledge score of learning disabilities. The ninth question assessed whether the participant would be more likely to

hang out with a male or female person with the specified disorder. All participants in all conditions completed both knowledge surveys.

### *Demographics Survey*

The demographics survey consisted of short questions that asked the participants to indicate their age, gender, level of education, and demographic information. The amount of contact the participants had with people with disabilities was surveyed using multiple questions that were designed for the purpose of this study. Participants were asked to indicate whether they had any contact with individuals with disabilities and whether they had been diagnosed with a disability themselves. They were also to indicate whether they had a close relative diagnosed with a disability, a distant relative a close friend, an acquaintance, a co-worker, and/or a patient/client with a disability label. In addition to who the participant knew with a disability, they were asked to report the disability label of each person they knew with a disability. Participants were also asked to rate the amount of personal contact they engaged in with persons with disabilities in their family, social life, work, and education major on a weekly basis, on a scale of 1-5 (1: Never, 2: Rarely, 3: Sometimes, 4: Often, 5: Always). In addition, they rated the amount of contact they engaged in with persons with disabilities within the past year in their family, social life, work, and education major on the same scale of 1-5 (1: Never, 2: Rarely, 3: Sometimes, 4: Often, 5: Always). The last question asked them to report if they had taken a class related to special education during their education. (see Appendix H)

## CHAPTER IV

### RESULTS

#### *Descriptive and Demographic Information*

Of the 163 participants included in this study, 63 were males (38.7%) and 100 were females (61.3%). All were undergraduate college students enrolled in education and introductory psychology courses at Oklahoma State University. The age of the participants ranged from 18 to 38 ( $M = 21.64$  years,  $SD = 3.29$ ). Table 1 presents the demographic information of the sample. The sample contained seven different ethnicities/races: African American ( $n = 12$ , 7.4%), Asian ( $n = 2$ , 1.2%), Caucasian ( $n = 122$ , 74.8%), Hispanic ( $n = 2$ , 1.2%), Native American ( $n = 14$ , 8.6%), other ( $n = 1$ , 0.6%), mixed ( $n = 10$ , 6.1%). About 60.7% had taken a class related to special education during their education, while 39.3% had not received a special education related class during their education.

Within the sample, 89% of participants had some contact with people with disabilities, while 11% had no contact with persons with disabilities. Five participants (3%) had been diagnosed with a disability themselves. In the sample 8% had a close relative diagnosed with a disability, while 4.3% had a distant relative diagnosed with a disability. In addition, 6.1% had a close friend with a disability, 18.4% knew an acquaintance, 1.8% knew a co-worker, and 2.5% had a patient/client with a disability

label. In addition to who the participant knew with a disability, they were asked to report the disability label of each person they knew with a disability. Autistic disorder was the known disability label in 4.9% of the cases, 4.3% were learning disorder, down syndrome in 4.3%, and ADHD/ADD in 2.5% of the cases. The disability was physical in 2.5%, but the specific label was unknown and similarly unknown in 0.6% neurological cases. The participant was unsure about the disability label in 52.8% of the cases. In 15.3% the person(s) that the participant had been in contact with had multiple disabilities. No disability label was reported by 12.9% of the participants.

Table 1

*Participant Demographics*

Variable	Percentage of Sample
Gender	
Male	38.70%
Female	61.30%
Race	
African American	7.40%
Asian	1.20%
Caucasian	74.80%
Hispanic	1.20%
Native American	8.60%
Other	6.70%
Interaction with specific disabilities	
None	12.9%
Autism	4.90%
Down Syndrome	4.30%
Neurological	0.60%
Physical	2.50%
ADHD	2.50%
Learning Disabled	4.30%
Multiple disability	15.30%
Unknown disability	52.80%



Participants were also asked to rate the amount of personal contact they engage in with persons with disabilities in their family, social life, work, and education major on a weekly basis, on a scale of 1-5 (1: Never, 2: Rarely, 3: Sometimes, 4: Often, 5: Always). In addition, they rated the amount of contact they engaged in with persons with disabilities within the past year in their family, social life, work, and education major on the same scale of 1-5. Table 2 presents these questions. In general, participants reported having the most contact with persons with disabilities in their social life, both on a weekly basis ( $M = 2.58$ ,  $SD = 1.05$ ), and within the past year ( $M = 2.49$ ,  $SD = 1.11$ ). The second most frequent occurrence of contact was within their education major classes both on a weekly basis ( $M = 2.51$ ,  $SD = 1.16$ ), and within the past year ( $M = 2.43$ ,  $SD = 1.22$ ). Following was contact with family on a weekly basis ( $M = 2.26$ ,  $SD = 1.46$ ) and within the past year ( $M = 2.28$ ,  $SD = 1.47$ ). The least amount of engaged contact occurred in the work environment on a weekly basis ( $M = 2.17$ ,  $SD = 1.18$ ), and within the past year ( $M = 2.14$ ,  $SD = 1.22$ ).

Table 2

*Descriptive Statistics of Participants*

Variable	M	SD
cFamily	2.26	1.46
cSocial	2.58	1.05
cWork	2.17	1.18
cMajor	2.51	1.16
yrFamily	2.28	1.47
yrSocial	2.49	1.11
yrWork	2.14	1.22
yrMajor	2.43	1.22

Note: **c** = amount of personal contact with persons with disabilities;  
**yr** = contact with persons with disabilities within the past year.

Table 3

*Cell Means*

Vignette Gender	Vignette Label	M	SD	N
Female	Autistic Disorder	68.74	11.53	27
	Learning Disorder	72.34	12.39	29
	No Label (control)	71.56	11.18	27
	Total	70.92	11.69	83
Male	Autistic Disorder	62.36	14.75	28
	Learning Disorder	63	16.42	27
	No Label (control)	72.92	11.23	25
	Total	65.88	14.98	80
Total	Autistic Disorder	65.49	13.54	55
	Learning Disorder	67.87	15.09	56
	No Label (control)	72.21	11.12	52
	Total	68.44	13.6	163

Table 4

*ANOVA Summary Table*

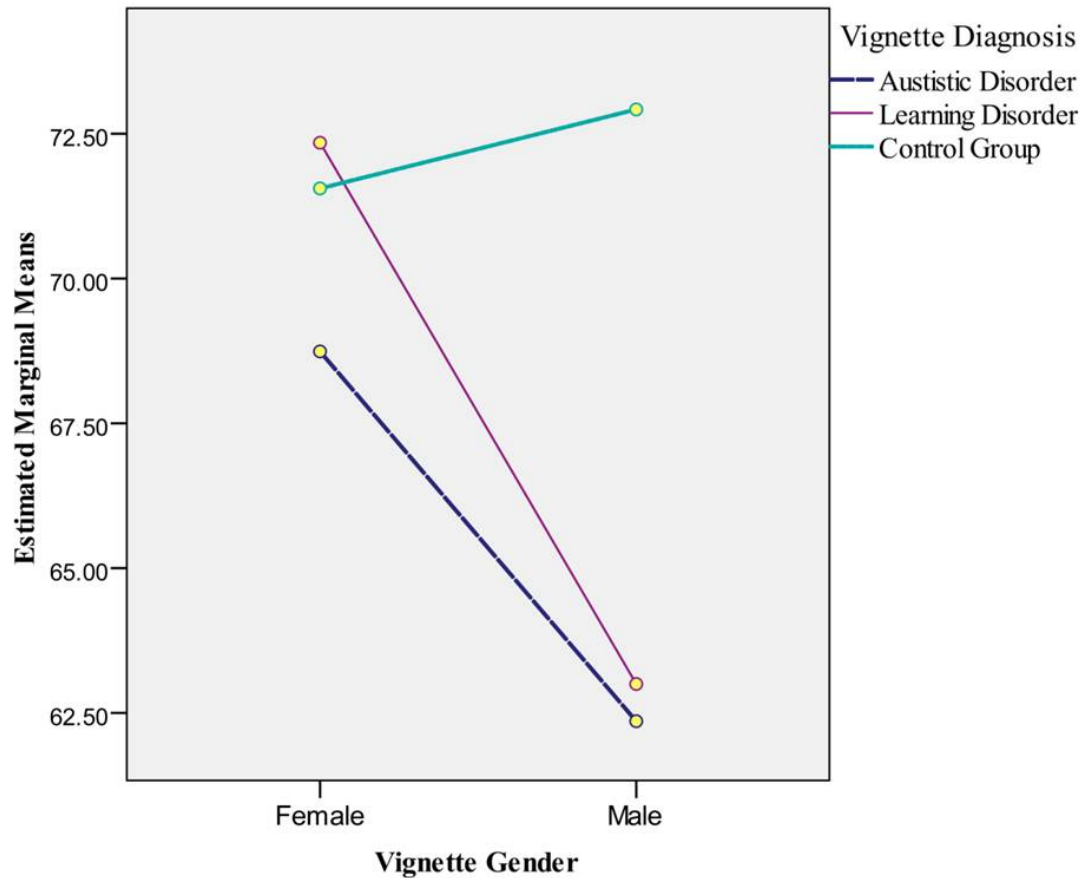
Source	Type III Sum of Squares	df	Mean Square	F	Sig.
Vignette Gender	932.29	1	932.29	5.44	0.021
Vignette Label	1241.26	2	620.63	3.62	0.029
Vignette Gender * Vignette Label	815.86	2	407.93	2.38	0.096
Error	26916.67	157	171.44		
Total	29960.20	162			

*Analyses*

Data were analyzed using a 2 x 3 analysis of variance, with disability status (autism, learning disorder, or no disability) and gender (male, female) of the individual

depicted in the vignette as the independent variables and rated prognostic outlook as the dependent variable. See Table 3 for cell means and standard deviations. A correlation was used to examine prognostic outlook, attitudes toward disabled persons, knowledge of autistic disorder and knowledge of learning disabilities. As shown in the Analysis of Variance summary table in Table 4, a significant interaction was found between vignette gender and vignette label  $F(2, 157) = 2.38, p = 0.096, \eta^2 = 0.029$ . This interaction is displayed graphically in Figure 1. When no disability label was mentioned in the vignette, participants rated males and females similarly on prognostic outlook, however, males were rated slightly higher. However, when either disability label was present, the prognostic outlook for males was rated lower than females.

Figure 1 *Estimated Marginal Means of Prognostic Outlook Depending on the Interaction between Vignette Label and Vignette Gender*



Simple main effects tests were used to compare the average rating of each male and female to each label category. These results, displayed in Table 5, revealed a significant difference between rated prognostic outlooks of females with a learning disability compared to males with a learning disability. These findings indicate that the mean score for males with a learning disability ( $M = 63.00$ ,  $SD = 16.42$ ) were rated

significantly lower on prognostic outlook than females with a learning disability ( $M = 72.34$ ,  $SD = 12.39$ ). The effect size for this difference was  $d = .64$ .

Table 5

*Univariate Test of Simple Main Effects*

Vignette Label		Sum of Squares	df	Mean Square	F	Sig.
Autistic Disorder	Contrast	560.13	1	560.13	3.27	0.073
	Error	26916.67	157	171.44		
Learning Disorder	Contrast	1221.00	1	1221.00	7.12	0.008
	Error	26916.67	157	171.44		
Control (No Label)	Contrast	24.17	1	24.17	0.14	0.708
	Error	26916.67	157	171.44		

The ATDP survey had a total of 180 possible points, as it had 30 questions, each ranging from one to six points ( $M = 110.14$ ,  $SD = 10.87$ ). The Prognostic Outlook survey had a total of 90 possible points, as it had nine questions, each ranging from one to ten points ( $M = 68.44$ ,  $SD = 13.60$ ). The knowledge of autistic disorder survey had a total of eight possible correct answers, as it had eight DSM-IV-TR criteria questions, each worth one point ( $M = 5.60$ ,  $SD = 1.60$ ). The knowledge of learning disabilities survey also had a total of eight possible correct answers, ( $M = 5.03$ ,  $SD = 1.35$ ). For an alpha level at .01, the correlation between prognostic outlook and attitudes toward individuals with disabilities was found to be statistically significant,  $r(1) = .38$ , indicating that attitudes about people with disabilities were related to their perception of how successful people with disabilities will be in life. No other significant correlations were found.

## CHAPTER V

### DISCUSSION

This study contributes to the empirical literature regarding the impact special education labels can have on the social relationships of young adults. The significant interaction effect between vignette gender and vignette label suggests that the perception of how successful people with disabilities will be in life is influenced by both the disability label and gender of the individual with a disability (Figure 1). The outcomes of this study suggest that females have a significantly higher prognostic outcome than males when the learning disability label is assigned.

Outcomes from the simple main effects tests revealed a significant difference between rated prognostic outlooks of females with a learning disability compared to males with a learning disability. Males with a learning disability were rated significantly lower on prognostic outlook than females with a learning disability (Table 5). The effect size for this difference was  $d = .64$ . In addition, the main effect of vignette gender on prognostic outlook indicated that girls were judged to be more likely than boys to be successful in life and develop and maintain adequate interpersonal relationships. The research related to gender differences in child psychopathology is complex, but the effects of gender are believed to be critical for understanding emotional and behavioral disorders (Mash & Dozois, 1996). Generally, more boys have been reported to have

externalizing and learning problems than girls; while more girls have been noted to have more internalizing problems (Achenbach, Howell, Quay, & Conners, 1991). There tends to be a societal perception that females are better at coping with difficult situations and are more responsible. The current results suggest that girls are indeed perceived as more likely to develop and maintain satisfactory interpersonal relationships and succeed in life.

The main effect of label revealed a significant difference between the label of autism and the control group, indicating that the prognostic outlook for individuals with autism were rated significantly lower than the control group with no label. This effect size was moderate in size,  $d = .54$ . No other significant differences were noted. It is possible that all of the participants in this study were simply more familiar with the label of learning disorder and had acquired more information for that label. It is most likely that participants knew of someone with a learning disability who has attended college. This familiarity may influence their perception that people with learning disabilities are more similar to people without disabilities and also more likely to succeed in life, than to people with autistic disorder.

The first hypothesis in this study predicted that autistic disorder would be rated lower than the control group. This was met since there was a significant difference between the label of autism and the control group. The second hypothesis was that learning disorder would be rated lower than the control group. This was not met since the difference between the label of learning disorder and control group was not statistically significant. However, it can be argued that this difference was approaching significance. The third hypothesis was that the control group would have the highest prognostic outlook, then learning disabilities and then autism rated lowest, which was partially met.



Lastly, it was predicted that females would be rated higher than males regardless of disability label. This was partially true, as simple main effects tests revealed that males with a learning disability were rated significantly lower on prognostic outlook than females with a learning disability.

The correlation between prognostic outlook and attitudes toward individuals with disabilities indicates that attitudes held about people with disabilities were related to their perception of how successful people with disabilities will be in life. The mean attitude score on the ATDP survey, ( $M = 110.14$ ,  $SD = 10.87$ ) was at the middle to middle-high range. This indicates that the average participant did not view people with disabilities as highly similar or highly different to individuals without disabilities. As a high score, relative to other scores indicates that the respondent perceives individuals with disabilities to be similar to individuals without disabilities. A score that is low would indicate that the respondent perceives individuals with disabilities to be different from individuals without disabilities (Yuker et al., 1966). Most of the items on the ATDP suggest that where there is a difference perceived, this difference has negative connotations. These negative connotations suggest that a low score reflects the respondent's attitude that individuals with disabilities are different and also possibly disadvantaged or inferior (Yuker et al., 1966). The mean score on the Prognostic Outlook survey ( $M = 68.44$ ,  $SD = 13.60$ ) was at the middle-high range. The average participant answered 5.60 questions correct (62%) on the knowledge of autistic disorder survey and 5.03 questions correct (56%) on the knowledge of learning disabilities survey. No significant correlations were found between the knowledge surveys and the ATDP or between the knowledge surveys Prognostic Outlook scale.

### *Limitations*

Despite the significant findings, limitations of this study need to be considered. Because this study used an analogue method with a controlled written vignette, caution should be used before generalizing the results to actual practice. Much of the labeling bias research is limited because of the use of analogue methodology, allowing participants to make inferences based on their own perceptions and biases. In real life, information and observations would be available from various settings and sources. However, because certain effects have been shown to have practical significance the topic does warrant continued evaluation. Another limitation that should be considered is the restrictive sample. The sample contained undergraduate students who were studying psychology or education, which could bias results. In addition, some participants might have taken part in the study only for the incentive of extra credit. The fact that no significant correlations were found between the knowledge surveys and the ATDP or between the knowledge surveys Prognostic Outlook scale, may be indicative of a restrictive sample and furthermore, the psychometric validity of the knowledge surveys is unknown.

### *Future Research*

The results of this study provide other possible opportunities for future research. The study could be improved by adding more vignettes depicting individuals with additional different special education labels. Future research could use a video vignette showing individuals with a disability. Different ways of measuring participants' knowledge of disabilities would also be useful. Additionally, research may benefit from using a larger and more diverse sample. Studies should look at larger geographical areas

for future implications as different locations have different attitudes in the area of special education and labels. Including other geographic areas could also increase the diversity of the subjects and increase generalizability.

### *Implications*

This research may assist in understanding the impact special education labels have on the peer social relationships of young adults. It will also further understanding about the potential effect of disability labels on young people's expectations regarding the potential of their peers with disabilities to lead a successful life of college students. It is important for psychologists to be cognizant not only of the advantages of special education labeling for helping students, but also about the associated disadvantages. This awareness will prepare psychologists to take steps needed to combat any negative effects that may be associated with psychoeducational diagnoses of young people. There are serious effects of bias on individuals being labeled. Thus, it is especially relevant for the field of psychology to develop reliable and valid ways of evaluating, observing, and diagnosing children with disabilities. Those who work with individuals who are labeled, should become familiar with variables that can inadvertently have a negative impact on their judgments to prevent unintentional discrimination against those children. Hopefully, further evaluation in the area can lead to some simple steps that practitioners can take to reduce the negative effects of labels.

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## APPENDICES

APPENDIX A  
ADMINISTRATION SCRIPT



### Administration Script

**Administrator:** Please read the following script to students prior to (and during, as appropriate) their participation in this study to ensure all data is collected in a uniform manner. Read the italicized portion to the students.

*Thank you for participating in this study. This research study seeks to determine whether or not there are differences in peer relationships of social acceptability and prognostic outlook, on the basis of a label. Your involvement is purely voluntary, and you are welcome to withdraw at any time without consequences.*

*You should refer to your copy of the consent form should you need to contact the researcher or anyone else concerning the project or your rights. Please feel free to contact the researchers if you have specific questions regarding the study or its outcome.*

[Distribute extra copies of the Informed Consent Forms, if requested. Please answer any questions that your students may have, and let me know of any concerns.]

*I will now distribute an instrument packet to each person who has agreed to participate. Please read the directions at the beginning of each section and complete the section accordingly. Participation should last approximately 15-20 minutes. Start with the first page and go in order. Do not turn to the next page until you have completed the previous page.*

[Distribute an Instrument Packet to each person who has submitted a consent form. If you choose to administer the instruments at the end of class, you are welcome to allow students to leave once they are finished. Place all completed packets into the envelope, and seal it. Please return the envelope to the researcher no later than 24 hours after the data has been collected.]

*Thank you for your assistance with this project.*

APPENDIX B  
CONSENT FORM

### Consent Form

I, \_\_\_\_\_, hereby authorize or direct Sarah Blackburn-Ellis (B.S. psychology), to perform the procedures listed here.

- A. Purpose:** This research study seeks to determine whether or not there are differences in peer relationships of social acceptability and prognostic outlook, on the basis of a label.
- B. Procedure:** The research will be conducted in a survey format with 150 undergraduate college level students.
- C. Length of Participation:** It is estimated that your participation will require a total of 20 minutes. Your participation is entirely voluntary; you can withdraw your consent at any time and discontinue participation.
- D. Risks of Participation:** There are no known risks associated with this project which are greater than those ordinarily encountered in daily life.
- E. Benefits:** As a research participant, you will be exposed to the conduct of scientific psychological research and may gain insight into your own beliefs and attitudes. In addition, you will gain helpful information if you pursue the results obtained within this study.
- F. Confidentiality and Privacy:** All the questionnaires will be identified only by numerical codes. Information containing your name (i.e. informed consent form) will be kept separate from numbered materials and in a secure place. Therefore, all information provided will be anonymous. Participants have the option of obtaining results of this study. However, results are limited to main effects and significance for learning purposes. Students should contact either Sarah, Paul or Megan via email if they wish to obtain results from this study. No specific information pertaining to individual participants, location, or personal detail of any sort will be released.

The records of this study will be kept private. Any written results will discuss group findings and will not include information that will identify you ) or your child, if applicable). Research records will be stored securely and only researchers and individuals responsible for research oversight will have access to the records. It is possible that the consent process and data collection will be observed by research oversight staff responsible for safe guarding the rights and wellbeing of people who participate in research.

Consent forms are to be returned in a separate envelope from the questionnaire materials. Envelopes for all materials will be provided

- G. Compensation:** You may volunteer to participate in an on-going research project. This research will provide 2% of your total 5% extra credit grade. These participation

opportunities will usually be announced in class, and may be posted on the calendar on the course website. These participation opportunities will usually be announced in class, and may be posted on the calendar on the course website. The research projects have been reviewed by an independent ethical committee (University Institutional Review Board) whose members are drawn from across the entire academic community, and, if student research, are supervised by a faculty member. To actually get these extra credit points, you must follow the procedure announced by your instructor and have the researcher email the instructor that you did the research or sign a pre-determined form.

## **H. Contacts:**

Sarah Blackburn-Ellis  
B.S. Psychology  
410-937-3174  
[Sarah.Blackburnellis@okstate.edu](mailto:Sarah.Blackburnellis@okstate.edu)

I have been fully informed about the procedures listed here. I am aware of what I will be asked to do and of the risks and benefits in this study. I also understand the following statements:

I understand that participation is voluntary and that I will not be penalized if I choose not to participate. I also understand that I am free to withdraw my consent and end my participation in this project at any time without penalty after I notify the researchers.

If you have questions about your rights as a research volunteer, you may contact Dr. Shelia Kennison, IRB Chair, 219 Cordell North, Stillwater, Ok 74078, 405-744-1676 or [irb@okstate.edu](mailto:irb@okstate.edu).

I have read and fully understand the consent form. I sign freely and voluntarily. A copy has been given to me to keep.

Date: \_\_\_\_\_

Time: \_\_\_\_\_ (a.m./p.m.)

Signed: \_\_\_\_\_

I certify that I have provided explanation for all elements of this prom before requesting the subject to sign it.

Signed: \_\_\_\_\_  
Project director or authorized  
representative

Signed: \_\_\_\_\_  
Research Advisor: Dr. Gary Duhon

## APPENDIX C

### ATTITUDES TOWARDS DISABLED PERSONS SCALE

**ATDP-B**

Mark each statement in the left margin according to how much you agree or disagree with it. Please mark every one. Write 1, 2, 3, 4, 5, 6: depending on how you feel in each case.

1: I agree very much  
2: I agree pretty much  
3: I agree a little

4: I disagree a little  
5: I disagree pretty much  
6: I disagree very much

---

- \_\_\_\_\_ 1. People with disabilities are often unfriendly.
- \_\_\_\_\_ 2. People with disabilities should not have to compete for jobs with the physically normal people.
- \_\_\_\_\_ 3. People with disabilities are more emotional than other people.
- \_\_\_\_\_ 4. Most people with disabilities are more self conscious than other people.
- \_\_\_\_\_ 5. We should expect just as much from those who have disabilities as from those who do not have disabilities.
- \_\_\_\_\_ 6. Workers with disabilities cannot be as successful as other workers.
- \_\_\_\_\_ 7. People with disabilities usually do not make much of a contribution to society.
- \_\_\_\_\_ 8. Most people without a disability would not want to marry anyone who has a disability.
- \_\_\_\_\_ 9. People with disabilities show as much enthusiasm as other people.
- \_\_\_\_\_ 10. People with disabilities are usually more sensitive than other people.
- \_\_\_\_\_ 11. People with severe disabilities are usually untidy.
- \_\_\_\_\_ 12. Most people with disabilities feel that they are as good as other people.
- \_\_\_\_\_ 13. The driving test given to a person with disabilities should be more severe than the one given to those without disabilities.
- \_\_\_\_\_ 14. People with disabilities are usually sociable.

- \_\_\_\_\_ 15. Persons with disabilities usually are not as conscientious as physically normal persons.
- \_\_\_\_\_ 16. People with severe disabilities probably worry more about their health than those who have minor health related problems.
- \_\_\_\_\_ 17. Most people with disabilities are not dissatisfied with themselves.
- \_\_\_\_\_ 18. There are more misfits among those with disabilities than among those without disabilities.
- \_\_\_\_\_ 19. Most persons with disabilities do not get discouraged easily.
- \_\_\_\_\_ 20. Most persons with disabilities resent physically normal people.
- \_\_\_\_\_ 21. Children with disabilities should compete with physically normal children.
- \_\_\_\_\_ 22. Most persons with disabilities can take care of themselves.
- \_\_\_\_\_ 23. It would be best if persons with disabilities would live and work with persons without disabilities.
- \_\_\_\_\_ 24. Most people with severe disabilities are just as ambitious as physically normal people.
- \_\_\_\_\_ 25. People with disabilities are just as self confident as other people.
- \_\_\_\_\_ 26. Most persons with disabilities want more affection and praise than other people.
- \_\_\_\_\_ 27. People with disabilities are often less intelligent than people without disabilities.
- \_\_\_\_\_ 28. Most persons with disabilities are different from those without disabilities.
- \_\_\_\_\_ 29. People with disabilities don't want any more sympathy than other people.
- \_\_\_\_\_ 30. The way people with disabilities act is irritating.

APPENDIX D  
VIGNETTES



## Vignettes

1. John is a 20 year old male sophomore undergraduate college student at Oklahoma State University. He sees an academic facilitator once a week for assistance with time management and organization. His current GPA is 2.8 and his major is undecided. He attends class regularly and is usually quiet during class but tries to answer questions when called on by the professors during lecture. His professors and family describe him as being a polite person. He enjoys watching movies, listening to music, and playing rock band in his free time. He spends time playing with his dog outside and taking him on walks. He has been diagnosed with high functioning Autism.
  
2. John is a 20 year old male sophomore undergraduate college student at Oklahoma State University. He sees an academic facilitator once a week for assistance with time management and organization. His current GPA is 2.8 and his major is undecided. He attends class regularly and is usually quiet during class but tries to answer questions when called on by the professors during lecture. His professors and family describe him as being a polite person. He enjoys watching movies, listening to music, and playing rock band in his free time. He spends time playing with his dog outside and taking him on walks. He has been diagnosed as Learning Disabled.
  
3. John is a 20 year old male sophomore undergraduate college student at Oklahoma State University. He sees an academic facilitator once a week for assistance with time management and organization. His current GPA is 2.8 and his major is undecided. He attends class regularly and is usually quiet during class but tries to answer questions when called on by the professors during lecture. His professors and family describe him as being a polite person. He enjoys watching movies, listening to music, and playing rock band in his free time. He spends time playing with his dog outside and taking him on walks.
  
4. Jane is a 20 year old female sophomore undergraduate college student at Oklahoma State University. She sees an academic facilitator once a week for assistance with time management and organization. Her current GPA is 2.8 and her major is undecided. She attends class regularly and is usually quiet during class but tries to answer questions when called on by the professors during lecture. Her professors and family describe her as being a polite person. She enjoys watching movies, listening to music, and playing rock band in her free time. She spends time playing with her dog outside and taking it on walks. She has been diagnosed with high functioning Autism.
  
5. Jane is a 20 year old female sophomore undergraduate college student at Oklahoma State University. She sees an academic facilitator once a week for assistance with time management and organization. Her current GPA is 2.8 and her major is undecided. She attends class regularly and is usually quiet during class but tries to answer questions when called on by the professors during lecture. Her professors and family describe her as being a polite person. She enjoys watching movies, listening to music, and playing rock band in her free time. She spends time playing with her dog outside and taking it on walks. She has been diagnosed as Learning Disabled.
  
6. Jane is a 20 year old female sophomore undergraduate college student at Oklahoma State University. She sees an academic facilitator once a week for assistance with time management and organization. Her current GPA is 2.8 and her major is undecided. She attends class regularly and is usually quiet during class but tries to answer questions when called on by the professors during lecture. Her professors and family describe her as being a polite person. She enjoys watching movies, listening to music, and playing rock band in her free time. She spends time playing with her dog outside and taking it on walks.

APPENDIX E  
PROGNOSTIC OUTLOOK SCALE

Please complete this scale in reference to the case description and diagnosis you just read.

### **Prognostic Outlook Scale**

Given this case description and diagnosis please respond to the following questions using a scale from 1 to 10, with '1' meaning extremely unlikely and '10' meaning extremely likely.

1. This person will develop adequate and appropriate peer relationships \_\_\_\_\_
2. This person will develop adequate and appropriate relationships with family \_\_\_\_\_
3. This person will develop adequate and appropriate relationships with school staff \_\_\_\_\_
4. This person will obtain a college degree \_\_\_\_\_
5. This person will obtain and hold a job for a reasonable length of time (1 year or more) \_\_\_\_\_
6. This person will be a disruptive force in the classroom \_\_\_\_\_
7. This person will have problems with law enforcement authorities in the future \_\_\_\_\_
8. This person will need constant supervision by teachers to be successful in school \_\_\_\_\_

**Please rate this item from 1 to 10 also. "1" extremely poor adjustment to "10" extremely well adjusted**

9. What is this person's overall level of adjustment? \_\_\_\_\_

APPENDIX F

KNOWLEDGE SURVEY: AUTISTIC DISORDER

### Knowledge Survey: Autistic Disorder

Please answer the following questions by **circling TRUE or FALSE**

1. True/False      Individuals with Autistic Disorder are inflexible with change and routine.
2. True/False      Individuals with Autism display an abnormal development of social interaction and communication.
3. True/False      Individuals with Autistic Disorder show a restricted range of interests.
4. True/False      Autism does not affect speech or language.
5. True/False      Autistic people display unusual body movements such as hands clapping, finger flicking, rocking, dipping, and swaying.
6. True/False      Individuals with Autism show the same expressions of emotions and mood as people without Autism.
7. True/False      Autistic Disorder is a Pervasive Developmental Disorder.
8. True/False      People with Autistic Disorder have equal job and educational opportunities.
9. True/False      I would be more likely to hang out with a male person with Autistic Disorder, than a female.

- 1 True
- 2 True
- 3 True
- 4 False
- 5 True
- 6 False
- 7 True
- 8 False

APPENDIX G

KNOWLEDGE SURVEY: LEARNING DISORDER

### Knowledge Survey: Learning Disorder

Please answer the following questions by **circling TRUE or FALSE**

1. True/False      Learning Disorders are diagnosed when an individual's achievement on standardized tests is substantially below that expected for age and intelligence.
2. True/False      Approximately half of students in public schools have a Learning Disability.
3. True/False      Learning problems significantly interfere with academic achievement and activities of daily living.
4. True/False      Low self-esteem and demoralization may be associated with Learning Disorders.
5. True/False      Individuals with Learning Disorders have deficits in social skills and social adjustment.
6. True/False      If an individual has scholastic difficulties due to a lack of opportunity, poor teaching, or cultural factors they have a Learning Disorder.
7. True/False      The cause of Learning Disorders can always be linked to a genetic predisposition.
8. True/False      People with a Learning Disorder have equal job and educational opportunities.
9. True/False      I would be more likely to hang out with a male person with a Learning Disorder, than a female.

1 True  
2 False  
3 True  
4 True

5 True  
6 False  
7 False  
8 False

APPENDIX H  
GENERAL DEMOGRAPHIC FORM



### **General Demographic Form**

1. Age: \_\_\_\_\_

2. Sex: \_\_\_\_\_

3. Race/Ethnicity (Please **circle all** that apply):

African American

Hispanic

Asian

Native American

Caucasian

Other (Please specify) \_\_\_\_\_

4. What is your current Major? \_\_\_\_\_

5. In what capacity have you come into contact with persons with disabilities (please **circle all** that apply and state the disability (s))?

Myself \_\_\_\_\_

Close Relative \_\_\_\_\_

Distant Relative \_\_\_\_\_

Close Friend \_\_\_\_\_

Acquaintance \_\_\_\_\_

Co-Worker \_\_\_\_\_

Patient/Client \_\_\_\_\_

No Contact \_\_\_\_\_

Please use the following scale to answer the remaining questions and circle the number that applies to you.

Never= **1**      Rarely= **2**      Sometimes= **3**      Often= **4**      Always= **5**

6. How much personal contact do you engage in with persons with disabilities?

Family	1	2	3	4	5
--------	---	---	---	---	---

Social Life	1	2	3	4	5
-------------	---	---	---	---	---

Work	1	2	3	4	5
------	---	---	---	---	---

Major	1	2	3	4	5
-------	---	---	---	---	---

7. How much contact have you had with persons with disabilities within the past year?

Family	1	2	3	4	5
--------	---	---	---	---	---

Social Life	1	2	3	4	5
-------------	---	---	---	---	---

Work	1	2	3	4	5
------	---	---	---	---	---

Major	1	2	3	4	5
-------	---	---	---	---	---

8. During your education, have you ever participated in any classes related to special education?

(**Circle** your answer; If yes list how many you have participated in.)

Yes \_\_\_\_\_

No \_\_\_\_\_

APPENDIX I  
RESEARCH DESIGN

Research Design		
	Male	Female
Control	Male Control	Female Control
Autistic	Male Autistic	Female Autistic
Learning Disabled	Male Learning Disabled	Female Learning Disabled

APPENDIX J  
IRB APPROVAL

### Oklahoma State University Institutional Review Board

Date: Wednesday, March 25, 2009  
 IRB Application No ED0928  
 Proposal Title: The Impact of Labels on Peer Relations of College Students

Reviewed and Processed as: Exempt

**Status Recommended by Reviewer(s): Approved Protocol Expires: 3/24/2010**

Principal Investigator(s):

Sarah Blackburn-Ellis	Paul Hansmann	Georgette Yetter
4599 N. Washington St. Apt 2	716 N. Husband St. Apt. 18	442 Willard
Stillwater, OK 74075	Stillwater, OK 74075	Stillwater, OK 74078

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The IRB application referenced above has been approved. It is the judgment of the reviewers that the rights and welfare of individuals who may be asked to participate in this study will be respected, and that the research will be conducted in a manner consistent with the IRB requirements as outlined in section 45 CFR 46.

☒ The final versions of any printed recruitment, consent and assent documents bearing the IRB approval stamp are attached to this letter. These are the versions that must be used during the study.

As Principal Investigator, it is your responsibility to do the following:

1. Conduct this study exactly as it has been approved. Any modifications to the research protocol must be submitted with the appropriate signatures for IRB approval.
2. Submit a request for continuation if the study extends beyond the approval period of one calendar year. This continuation must receive IRB review and approval before the research can continue.
3. Report any adverse events to the IRB Chair promptly. Adverse events are those which are unanticipated and impact the subjects during the course of this research; and
4. Notify the IRB office in writing when your research project is complete.

Please note that approved protocols are subject to monitoring by the IRB and that the IRB office has the authority to inspect research records associated with this protocol at any time. If you have questions about the IRB procedures or need any assistance from the Board, please contact Beth McTernan in 219 Cordell North (phone: 405-744-5700, beth.mcternan@okstate.edu).

Sincerely,



Shelia Kennison, Chair  
 Institutional Review Board

## VITA

Sarah Lynn Blackburn-Ellis

Candidate for the Degree of

Master of Science

Thesis: BIASES IMPACTING INDIVIDUALS WHO HAVE BEEN GIVEN A  
LABEL

Major Field: School Psychology

### Education:

Bachelor of Science degree: Palm Beach Atlantic University,

Major: Psychology, Minor: Social Work, May 2008.

Completed the requirements for the Master of Science in School Psychology at  
Oklahoma State University, Stillwater, Oklahoma in December, 2009.

### Experience:

Graduate Research Assistant- Oklahoma State University, August 2008-Present

Academic Facilitator- Academic Excellence Center, August 2009-Present

Independent Reading Tutor, Reading and Mathematics Center, January 2009-  
Present

Practicum- Stillwater, OK, 240 hours, August 2008- Present

### Professional Memberships:

APA, NASP, APA Division 16, APAGS , SASP, OPA, OSPA, SPGO, Psi Chi  
National Honor Society.

### Honors and Distinctions:

Paul Warden & Mary Jo Keatley Award of outstanding accomplishment in  
graduate studies 2009

Graduated with Cum Laude Honors 2008

Who's Who Among Students in American Universities 2007-2008

Presidents List 2002-2008

Dean's List 2002-2008

PBA Achievement Award 2005-2008

PBA Sailfish Award (academic scholarship) 2005-2008

Name: Sarah Lynn Blackburn-Ellis

Date of Degree: December, 2009

Institution: Oklahoma State University

Location: Stillwater, Oklahoma

Title of Study: THE IMPACT OF LABELS ON PEER PERCEPTIONS OF  
PROGNOSTIC OUTLOOK

Pages in Study: 79

Candidate for the Degree of Master of Science

Major Field: Educational Psychology

Option: School Psychometrics

Scope and Method of Study:

The purpose of this study was to assess participants' social acceptance and prognostic outlook toward peers who have autistic disorder, learning disorder, or no disabilities and to explore the possibility that gender interacts with disability status in influencing participants' perceptions of peers with disabilities. Participants included 163 undergraduate college students. Measures of attitude toward disability and prognostic outlook were assessed using an attitude towards disabilities survey, a vignette, a prognostic outlook survey, a knowledge survey of autistic disorder, and a knowledge survey of learning disorder.

Findings and Conclusions:

Data were analyzed using a 2 x 3 analysis of variance, with disability status (autism, learning disorder, or no disability) and gender (male, female) of the individual depicted in the vignette as the independent variables and rated prognostic outlook as the dependent variable. A correlation was used to examine prognostic outlook, attitudes toward disabled persons, knowledge of autistic disorder and knowledge of learning disabilities. Results indicated a significant interaction between vignette gender and vignette disability label. Prognostic outlook was rated significantly lower for the autistic disorder group than for the group with no disability label. Results from simple main effects tests revealed a significant difference between rated prognostic outlooks of females with a learning disability compared to males with a learning disability. Indicating that males with a learning disability were rated significantly lower on prognostic outlook than females with a learning disability.

ADVISER'S APPROVAL: Dr. Gary Duhon

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